		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030015

Facility Name: WESTMONT CONVALESCENT CENTER

Address: 6501 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 960-2026 **Fax #** (630) 960-0480

IDPA ID Number: 36-3376606

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[X]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) FLORA WEISS

(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Previe

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	108	Skilled (SNF)	108	39,528	1
2		Skilled Pediatric (SNF/PED)			2
3	107	Intermediate (ICF)	107	39,162	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	215	TOTALS	215	78,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	11,113	3,338	6,834	21,285	8
9	SNF/PED					9
10	ICF	39,215	12,337	413	51,965	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,328	15,675	7,247	73,250	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.09%

D. How many bed-hold days during this year were paid by Public Aid?
687 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 4423

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	230,281	21,386	6,419	258,086		258,086	0	258,086			1
2	Food Purchase		242,454		242,454		242,454	(12,252)	230,202			2
3	Housekeeping	175,191	45,562	0	220,753		220,753	0	220,753			3
4	Laundry	138,349	36,400	6,840	181,589		181,589	0	181,589			4
5	Heat and Other Utilities			187,861	187,861		187,861	0	187,861			5
6	Maintenance	102,330	32,800	40,605	175,735		175,735	2,215	177,950			6
7	Other (specify):*			19,969	19,969		19,969	0	19,969			7
8	TOTAL General Services	646,151	378,602	261,694	1,286,447		1,286,447	(10,037)	1,276,410			8
	B. Health Care and Programs											
9	Medical Director			15,225	15,225		15,225	0	15,225			9
10	Nursing and Medical Records	2,329,767	158,604	17,235	2,505,606		2,505,606	0	2,505,606			10
10a	Therapy	117,085	299	3,073	120,457		120,457	0	120,457			10a
11	Activities	150,112	2,278	500	152,890		152,890	0	152,890			11
12	Social Services	26,478		1,041	27,519		27,519	0	27,519			12
13	Nurse Aide Training			8,660	8,660		8,660	0	8,660			13
14	Program Transportation			5,588	5,588		5,588	0	5,588			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,623,442	161,181	51,322	2,835,945		2,835,945		2,835,945			16
	C. General Administration											
17	Administrative	201,933		905,000	1,106,933		1,106,933	0	1,106,933			17
18	Directors Fees			0				0				18
19	Professional Services			49,257	49,257		49,257	0	49,257			19
20	Dues, Fees, Subscriptions & Promotions			36,498	36,498		36,498	(6,287)	30,211			20
21	Clerical & General Office Expenses	181,429	31,470	32,869	245,768		245,768	(5,376)	240,392			21
22	Employee Benefits & Payroll Taxes			605,451	605,451		605,451	0	605,451			22
23	Inservice Training & Education			4,754	4,754		4,754	0	4,754			23
24	Travel and Seminar			0				0				24
25	Other Admin. Staff Transportation			25,127	25,127		25,127	0	25,127			25
26	Insurance-Prop.Liab.Malpractice			74,201	74,201		74,201	0	74,201			26
27	Other (specify):*			59,409	59,409		59,409	(59,409)				27
28	TOTAL General Administration	383,362	31,470	1,792,566	2,207,398		2,207,398	(71,072)	2,136,326			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,652,955	571,253	2,105,582	6,329,790		6,329,790	(81,109)	6,248,681			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			344,699	344,699		344,699	10,380	355,079			30
31	Amortization of Pre-Op. & Org.			21,180	21,180		21,180	0	21,180			31
32	Interest			704,336	704,336		704,336	(131,272)	573,064			32
33	Real Estate Taxes			72,603	72,603		72,603	0	72,603			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			61,334	61,334		61,334	0	61,334			35
36	Other (specify):*							0				36
37	TOTAL Ownership			1,204,152	1,204,152		1,204,152	(120,892)	1,083,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		117,624	177,382	295,006		295,006	0	295,006			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			118,036	118,036		118,036	0	118,036			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		117,624	295,418	413,042		413,042		413,042			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,652,955	688,877	3,605,152	7,946,984	0	7,946,984	(202,001)	7,744,983			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	10,380	30		9
10	Interest and Other Investment Income	(131,272)	32		10
11	Discounts, Allowances, Rebates & Refunds	(11,388)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(864)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(5,376)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,405)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(59,409)	27		24
25	Fund Raising, Advertising and Promotional	(3,732)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	2,215	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (202,001)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	0	SCHED	34
35	Other- Attach Schedule	0	ITACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (202,001)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **WESTMONT CONVALESCENT CENTER**

ID# **0030015**

Report Period Beginning: **01/01/2000**

Ending: **12/31/2000**

Print Other Adjustment

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(12,252)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	2,215
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(10,037)
9	**Non-Straightline Depreciation**	10,380	30	**Line 9**	0
10	**Interest and Other Investment Income**	(131,272)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(11,388)	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(864)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	(150)	20	**Line 16**	0
18	**Fines and Penalties**	(5,376)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	(2,405)	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(6,287)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(5,376)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	(59,409)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(3,732)	20	**Line 24**	0
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	0	20	**Line 27**	(59,409)
29	**Non-Paid Workers**	0	0	**Line 28**	(71,072)
30	**Donated Goods**	0	0	**Line 29**	(81,109)
31	**Amortization Expense**	0	0	**Line 30**	10,380
32	Deferred Maint XIX-H	2,215	6	**Line 31**	0
33				**Line 32**	(131,272)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(120,892)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(202,001)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,252)	0	0	0	0	0	0	0	0	0	0	(12,252)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,215	0	0	0	0	0	0	0	0	0	0	2,215	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(10,037)	0	0	0	0	0	0	0	0	0	0	(10,037)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(6,287)	0	0	0	0	0	0	0	0	0	0	(6,287)	20
21	Clerical & General Office Expenses	(5,376)	0	0	0	0	0	0	0	0	0	0	(5,376)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(59,409)	0	0	0	0	0	0	0	0	0	0	(59,409)	27
28	**TOTAL General Administration**	(71,072)	0	0	0	0	0	0	0	0	0	0	(71,072)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,109)	0	0	0	0	0	0	0	0	0	0	(81,109)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	10,380	0	0	0	0	0	0	0	0	0	0	10,380	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(131,272)	0	0	0	0	0	0	0	0	0	0	(131,272)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(120,892)	0	0	0	0	0	0	0	0	0	0	(120,892)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(202,001)	0	0	0	0	0	0	0	0	0	0	(202,001)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOI

Facility Name & ID Number WESTMONT CONVALESCENT CENTE # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		SEE ATTACHED SCHEDULE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$ -			$ -	$ -	1
2	V		-			-	-	2
3	V		-			-	-	3
4	V		-			-	-	4
5	V		-			-	-	5
6	V		-			-	-	6
7	V		-			-	-	7
8	V		-			-	-	8
9	V		-			-	-	9
10	V		-			-	-	10
11	V		-			-	-	11
12	V		-			-	-	12
13	V		-			-	-	13
14	Total		$ -			$ -	$ - *	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6E, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6E, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6E, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6A

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Previe

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number WESTMONT CONVALESCENT CENTEF # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	FLORA WEISS	GEN. PARTNER	ADMINISTRAT.	0.223256	0	56	90	MGMT FEE	$ 452,500	17-3	1
2	DANIEL WEISS	ASST. ADM	ADMINISTRAT.	0		8	20	SALARY	38,844	17-1	2
3	SCHIRLEY HOLT	GEN. PARTNER	ADMINISTRAT.	0.1628	0	60	100	MGMT FEE	452,500	17-3	3
4	RICHARD HOLT	GEN. PARTNER	SECURITY	0	0	3	5	OUTS. LAB	4,750	6-3	4
5	NANCY GERACI	ADMINISTRAT.	ADMINISTRAT.	0.0093	0	40	100	SALARY	111,010	17-1	5
6	SHARON HAUGH	BOOKKEEPER	CLERICAL	0.0093	0	20	50	SALARY	43,807	21-1	6
7	JANE HOLT	CLERK	CLERICAL	0	0	12	0	SALARY	8,550	21-1	7
8	VASCO HOLD	CLERK	CLERICAL	0	0	14	0	SALARY	13,700	21-1	8
9	AVRUM WEINFELD	CONSULTANT	COMP. CONS.	0	0	1	0	SALARY	350	21-1	9
10											10
11											11
12											12
13								TOTAL	$ 1,126,011		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	NATIONAL REALTY FUNDING		X	MORTGAGE	$84,451.00	05/01/98	$ 10,000,000	$ 9,598,622	05/01/23	7.2800	$ 704,336	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$84,451.00		$ 10,000,000	$ 9,598,622			$ 704,336	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 9,598,622			$ 704,336	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Previe

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	73,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	72,603	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,197)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	73,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	72,603	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	67,994	8
	1996	68,221	9
	1997	70,426	10
	1998	72,625	11
	1999	72,603	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,928 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		0	1995	$ 349,103	1
2					2
3	TOTALS	126,000		$ 349,103	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1995		$ 4,982,301	$ 127,746	127746	$ 127,746	$	$ 740,020	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	FLOORING			1986	41,641	2,207	19	2,192	(15)	30,091	9
10	ROOF &WATER LINE			1987	31,143	989	20	1,557	568	21,012	10
11	IMPROVEMENTS			1988	44,614	1,417	31.5	1,417		17,693	11
12	IMPROVEMENTS			1989	40,935	1,299	31.5	1,299		14,880	12
13	DRIVEWAY			1989	17,137	1,142	15	1,142		10,038	13
14	IMPROVEMENTS			1990	37,367	1,187	31.5	1,187		12,400	14
15	IMPROVEMENTS			1991	45,002	1,428	31.5	1,428		13,327	15
16	IMPROVEMENTS			1992	49,649	1,577	31.5	1,577		13,311	16
17	ROOF TOP A/C UNITS			1993	9,100	289	31.5	289		2,288	17
18	IMPROVEMENTS			1993	53,243	1,366	39	1,366		10,095	18
19	IMPROVEMENTS			1994	31,230	801	39	801		5,323	19
20	FLOOR COVERING			1995	795	20	15	53	33	318	20
21	HAND RAIL			1995	2,249	58	39	58		341	21
22	FLOOR & TILES			1995	5,471	140	39	140		788	22
23	WINDOW A/C UNITS			1995	14,146	363	39	363		1,980	23
24	ARJO TUB & ATTACHED PLUMBING			1995	12,056	309	39	309		1,713	24
25	ALARM			1995	1,337	34	39	34		186	25
26	LAUNDRY BUILDING			1995	35,000	897	39	897		4,747	26
27	ROOF			1995	5,520	142	39	142		751	27
28	WINDOWS			1995	9,478	243	39	243		1,266	28
29	DOOR EDGE & DOOR FRAME			1996	2,099	54	39	54		268	29
30	LAUNDRY BUILDING			1996	175,187	4,492	39	4,492		20,405	30
31	AIR COOLERS			1996	6,642	171	39	171		767	31
32	RACING CAGE			1996	3,987	102	39	102		463	32
33	HAND RAIL			1996	1,156	30	39	30		131	33
34	WINDOWS			1996	11,496	295	39	295		1,291	34
35	TACK ROOM			1996	2,139	55	39	55		236	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 148,853		$ 149,439	$ 586	$ 926,129	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	NEW CONFERENSE ROOM-TILE			1997	2,938	76	39	76		250	9
10	INSTALL DIETARY DOOR			1997	1,478	38	39	38		125	10
11	NURSING STATION- 2ND FLOOR			1997	5,397	138	39	138		432	11
12	WINDOW-NURSING OFFICE			1997	1,382	35	39	35		109	12
13	REPLACEMENT A/C HEATING UNIT			1997	1,107	28	39	28		111	13
14	NURSING STATION-FLOOR TILES, HANDRAILS			1997	4,927	126	39	126		342	14
15	THE PARKING LOT			1998	42,711	2,847	15	2,847		5,931	15
16	KICHEN BACK-REPLACE TILES, SIX ROOMS- INSTALL TILES			1998	6,223	160	39	160		463	16
17	INSTALL 6" SEWER, 10 EMERGENCY PULL CORD			1998	12,715	326	39	326		693	17
18	GENERATOR BACK-UP HOOK-UP TO ELEVATOR			1999	10,473	269	39	269		527	18
19	REPLACEMENT OF WATER HEATER - 1-ST FLOOR			1999	3,452	89	39	89		152	19
20	ANSUL FIRE SUPPRESSI ON SYSTEM INSTALL			1999	1,495	38	39	38		65	20
21	SEALCOATING, REPAIRS & LINING			1999	2,877	74	39	74		120	21
22	REMODELING F WING SHOWER ROOM			1999	8,988	230	39	230		355	22
23	REPLACE DEFECTIVE SMOKE DETECTORS			1999	2,370	61	39	61		89	23
24	THE NEW PROXIMITY ELEVATOR DOOR EDGE			1999	2,760	71	39	71		86	24
25	WATER HEATER - DIETARY			1999	2,931	75	39	75		84	25
26	ROOF TOP - TWO EXHAUST FANS			1999	3,073	79	39	79		89	26
27	TILE - DINING ROOM			1999	1,212	31	39	31		35	27
28	ROOF - REPAIRS AND COATINGS			1999	7,200	185	39	185		208	28
29	REPLACE HEAT EXCHANGER IN YORK ROOF TOP UNIT			1999	2,738	70	39	70		73	29
30	WINDOW TREATMENT, DRAPERY			2000	3,265	117	20	163	46	163	30
31	WATER HEATER-DIETARY			2000	3,573	38	27.5	38		38	31
32	GENERAL CONSTRUCTION			2000	27,448	208	27.5	208		208	32
33	ROOF REPAIR			2000	4,200	32	27.5	32		32	33
34	REPLACE ELECTRIC PANEL INTERIOR			2000	2,910	4	27.5	4		4	34
35	NEW A/C UNIT ROOF TOP			2000	4,694	7	27.5	7		7	35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 5,452		$ 5,498	$ 46	$ 10,791	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	WALLCOVERING, FLOORING, LIGHTING			2000	80,523	2,875	20	4,026	1,151	4,026	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 2,875		$ 4,026	$ 1,151	$ 4,026	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,974,511	$ 184,949	$ 194,947	$ 9,998	4-15	$ 1,066,583	37
38	Current Year Purchases	23,373	2,570	1,169	(1,401)	8-10	1,169	38
39	Fully Depreciated Assets	94,918					94,918	39
40								40
41	TOTALS	$ 2,092,802	$ 187,519	$ 196,116	$ 8,597		$ 1,162,670	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 344,699	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 355,079	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 10,380	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,103,616	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 34,048 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	HSKP, MAINT.	1998 DODGE VAN	$ 550.00	$ 6,600	17
18	ADM	1999 VOLVO	915.00	9,146	18
19	ADM	1998 BMW	#######	11,540	19
20					20
21	TOTAL		$ #######	$ 27,286	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 91

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 690	$	$ 690
2	Books and Supplies		2,077		2,077
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		5,893		5,893
9	TOTALS	$	$ 8,660	$	$ 8,660
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,660			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 60,656	$		$ 60,656	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			10,505			10,505	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			79,317			79,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				96,715		96,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	RENTALS, LAB, RADIOLOGY	39-2					11,064		11,064	
13	Other (specify): MEDICAL SUPPLIES	39-2					36,749		36,749	13
14	TOTAL			$		$ 150,478	$ 144,528		$ 295,006	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Previe

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,215,859	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	944,723		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	104,144		6
7	Other Prepaid Expenses	44,993		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Dep. $ Insurance	64,693		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,374,412	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	349,103		13
14	Buildings, at Historical Cost	4,982,301		14
15	Leasehold Improvements, at Historical Cost	944,879		15
16	Equipment, at Historical Cost	2,092,802		16
17	Accumulated Depreciation (book methods)	(2,695,118)		17
18	Deferred Charges	254,413		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Amort Of Def MTG Cost	(56,480)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,871,900	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,246,312	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 191,170	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,066		30
31	Accrued Taxes Payable (excluding real estate taxes)	49,983		31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	21,703		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 456,722	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	9,598,622		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 9,598,622	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,055,344	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (809,032)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,246,312	$	48

***(See instructions.)**

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (765,888)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (765,888)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,160,856	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,204,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (43,144)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (809,032)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,745,915	1
2	Discounts and Allowances for all Levels	(133)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,745,782	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	224,870	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 224,870	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	16,231	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 16,231	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	131,272	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 131,272	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	11,388	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,388	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,129,543	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,286,447	31
32	Health Care	2,835,945	32
33	General Administration	2,207,398	33
	B. Capital Expense		
34	Ownership	1,204,152	34
	C. Ancillary Expense		
35	Special Cost Centers	295,006	35
36	Provider Participation Fee	118,036	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,946,984	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,182,559	41
42	**Income Taxes**	21,703	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,160,856	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**

IRS SECTION 481 ADJ DEFERRAL

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,200	$ 65,250	$ 29.66	1
2	Assistant Director of Nursing	2,080	2,200	54,456	24.75	2
3	Registered Nurses	39,712	46,218	777,855	16.83	3
4	Licensed Practical Nurses	11,333	11,860	197,846	16.68	4
5	Nurse Aides & Orderlies	107,554	111,395	1,037,092	9.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,709	9,717	117,085	12.05	8
9	Activity Director	2,080	2,264	37,882	16.73	9
10	Activity Assistants	13,252	14,064	112,230	7.98	10
11	Social Service Workers	1,993	2,321	26,478	11.41	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,191	41,503	18.94	13
14	Head Cook					14
15	Cook Helpers/Assistants	25,239	26,777	188,778	7.05	15
16	Dishwashers					16
17	Maintenance Workers	9,278	10,517	102,330	9.73	17
18	Housekeepers	29,541	30,681	175,191	5.71	18
19	Laundry	21,813	22,905	138,349	6.04	19
20	Administrator	2,080	2,200	111,010	50.46	20
21	Assistant Administrator	4,160	4,400	90,923	20.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,953	13,416	181,429	13.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,320	12,048	148,260	12.31	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Superv	2,080	2,433	49,008	20.14	33
34	TOTAL (lines 1 - 33)	306,337	329,807	$ 3,652,955 *	$ 11.08	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	100	$ 4,791	1-3	35
36	Medical Director	Monthly	15,225	9-3	36
37	Medical Records Consultant	24	1,065	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	Monthly	2,220	10-3	39
40	Physical Therapy Consultant	46	2,310	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	10	500	11-3	44
45	Social Service Consultant	21	1,041	12-3	45
46	Other(specify) ALZHEIMER'S	8	400	10-3	46
47	REHABILITATION	15	763	10a-3	47
48	UTILIZATION REVIEW FEES	Monthly	3,100	10-3	48
49	TOTAL (lines 35 - 48)	224	$ 31,415		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	534	10,450	10-3	52
53	TOTAL (lines 50 - 52)	534	$ 10,450		53

Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NANCY GERACI	ADMIN	93.00%	$ 111,010
MARY LYNN MOUNT	ASSIT ADM	0.00%	52,079
DANIEL WEISS	ASSIT ADM	0.00%	38,844
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 201,933

B. Administrative - Other

Description		Amount
FLORA WEISS	MANAGEMENT FEE	$ 452,500
SHIRLEY HOLT	MANAGEMENT FEE	452,500
TOTAL (agree to Schedule V, line 17, col. 3)		$ 905,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 6,482
HEALTH DATA SYSTEM	DATA PROCESSING	15,421
MID AMERICA PROGR	DATA PROCESSING	1,320
HC/ACCU-MED	DATA PROCESSING	3,165
KBKB, FR & R	ACCOUNTING FEE	11,255
RICHARD PEELO	MEDICARE CONSULT	4,500
PERESONNEL PLANNERS	U/C CONSULTANT	827
LARRY CHAMBERS	LEGAL FEE	1,012
LEVIN,GOODMAN & COHEN	LEGAL FEE	984
SACHNOFF & WEAVER	LEGAL FEE	3,157
LAWRENCE SCHWARTZ	LEGAL FEE	940
LANER MUCHIN	LEGAL FEE	194
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 49,257

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,192
Unemployment Compensation Insurance	25,662
FICA Taxes	273,712
Employee Health Insurance	128,483
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	97,910
EMPLOYEE PHYSICAL EXAMS	2,492
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,451

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,104
Health Care Worker Background Check	300
(Indicate # of checks performed 25)	
ADV & PROMO/MARKETING	3,732
DUES & SUBSCRIPTIONS	6,582
LICENSES & PERMITS	1,225
TRUST FEES, CONTRIBUTIONS,etc.	2,555
MGMT CO ALLOCATION	0
LESS TRUST FEES, CONTRIB, etc.	(2,555)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,732)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,211

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	0
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	7/97	$ 11,173	3 YR	$ 1,862	$ 3,724	$ 3,724	$ 1,863	$	$	$	$	$
2	PAINT/DECORATINC	7/98	7,598	3 YR		1,267	2,532	3,532	1,267				
3	PAINT/DECORATINC	7/99	9,577	3 YR			1,596	3,192	3,192	1,597			
4	PAINT/DECORATINC	7/00	7,646	3 YR				1,274	2,549	2,549	1,274		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 35,994		$ 1,862	$ 4,991	$ 7,852	$ 9,861	$ 7,008	$ 4,146	$ 1,274	$	$

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER # 0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $5982

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 47,991 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
WESTMONT TERRACE NURSING CENTER, # 0025981. 9/1/85

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 118,036
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

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Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	4791	
	REPAIRS & MAINTENANCE		1628	
			0	6419
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		6840	
			0	6840
5	HEAT & OTHER UTILITIES			
	GAS HEAT		39411	
	ELECTRICITY		84735	
	WATER		63715	
	CABLE TV - LOBBY		0	
			0	187861
6	MAINTENANCE			
	GROUNDS MAINTENANCE		5955	
	PAINTING & DECORATING		7646	
	BUILDING REPAIRS		1360	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5703	
	ELEVATOR MAINTENANCE & REPAIR		5737	
	OUTSIDE LABOR		4750	
	EXTERMINATING SERVICE		4250	
	FIRE SERVICE		5204	
			0	
			0	40605
7	OTHER			
	SCAVENGER		19969	
	SECURITY SERVICE		0	19969
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	15225	15225
10	NURSING			
	CONTRACT NURSING	XVIII C53	10450	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES			
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B38		
	MEDICAL RECORDS CONSULTANT	XVIII B37	1065	
	PHARMACY CONSULTANT	XVIII B39	2220	
	UTILIZATION REVIEW FEES	XVIII B	3100	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	0	
	ALZHEIMER'S		400	
			0	17235
10a	THERAPY			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	763	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	2310	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	0	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	3073
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	500	
			0	500
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	1041	
			0	1041
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	8660	8660

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		5588	5588
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	905000	905000
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	26388	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	22869	
	ACCOUNT COLLECTION FEES		0	49257
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	3732	
	EMPLOYEE WANT ADS	XIX F	22104	
	CONTRIBUTIONS	VI 20 XIX F	625	
	DUES & SUBSCRIPTIONS	XIX F	6582	
	LICENSES & PERMITS	XIX F	1225	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1780	
	H/CARE WORKER BACKGROUND CHECK	XIX F	300	36498
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		234	
	EQUIPMENT REPAIR & MAINTENANCE		604	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES	VI 18	5376	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		26655	
	MESSENGER SERVICE		0	
			0	32869

LINE		SCHED REF		TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	273712	
	UNEMPLOYMENT COMPENSATION	XIX D	25662	
	WORKERS COMPENSATION INSURANCE	XIX D	77192	
	HOSPITALIZATION INSURANCE	XIX D	128483	
	EMPLOYEE BENEFITS - OTHER	XIX D	97910	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2492	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING CONTRIB	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	605451
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		4754	4754
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
				0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		25127	25127
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		74201	74201
27	OTHER			
	BAD DEBTS	VI 24	59409	
			0	59409
	GRAND TOTAL COLUMN 3 OTHER			2105582

WESTMONT CONVALESCENT CENTER - DIAGNOSTICS - 12/31/2000
This report reflects a 366-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 32-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5 Line 29-1 consists of 9861 from Page 22 and -7646 from Page 3 Line 6-3.
Related organization cost on Page 5 Line 34 = Page 6 Line 14-8.

Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest expense on Page 4 Line 32-4 = Page 9 Line 15-10.
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depreciation expense on Page 4 line 30-4 = Page 13 Line 48-2.
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 49-2.
Facility rent on Page 4 Line 34-4 = Page 14 Line 7-4.
Equipment rent on Page 4 Line 35-4 = Page 14 Line 16 + Line 21-4.
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 10-1.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 41-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.

Facility Name & ID Number WESTMONT CONVALESCENT CENTER #0030015

EMPLOYEE MEAL RECLASSIFICATION

PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	0	PATIENT MEALS	219750
LESS SALES TAX	-864	ADD EMPLOYEE MEALS	0
NET FOOD	864	TOTAL MEALS/YEAR	219750
TOTAL PATIENT CENSUS	73250	NET FOOD	864
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	219750
TOTAL PATIENT MEALS	219750	COST PER MEAL	0
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

WESTMONT CONVALESCENT CENTER - COMPARISONS - 12/31/2000

	ref.	12/31/2000			12/31/1999			DIFF	12/31/1998		
CAPACITY DAYS		78690			78475			215	78475		
CENSUS DAYS		73250			73361			-111	74676		
OCCUPANCY %		0.93086796			0.93483275				0.95158968		
SALARIES											
TOTAL General Services	8-1	646151	0.08342833	8.82117406	649156	0.08914377	8.84878887	-3005	609900	0.07297516	8.16728266
Social Services	12-1	26478	0.00341873	0.3614744	25488	0.00350008	0.34743256	990	124195	0.01486006	1.663118
TOTAL Health Care and Programs	16-1	2623442	0.33872792	35.8149078	2436917	0.33464371	33.2181541	186525	2356204	0.28192224	31.5523595
Clerical & General Office Expenses	21-1	181429	0.02342536	2.47684642	168791	0.02317881	2.30082742	12638	152345	0.01822824	2.04007981
TOTAL General Administration	28-1	383362	0.04949811	5.23361092	356923	0.04901358	4.86529627	26439	334881	0.04006886	4.48445284
TOTAL Operation Expense	29-1	3652955	0.47165436	49.8696928	3442996	0.47280107	46.9322392	209959	3300985	0.39496626	44.204095
ADJUSTED TOTALS								0			
Food	2-8	230202	0.02972273	3.14268942	220442	0.03027166	3.00489361	9760	215374	0.02576972	2.8841127
Heat and Other Utilities	5-8	187861	0.02425583	2.56465529	167899	0.02305632	2.28866837	19962	165023	0.01974517	2.20985323
Maintenance	6-8	177950	0.02297616	2.42935154	188618	0.02590151	2.57109363	-10668	187931	0.02248614	2.51661846
TOTAL General Services	8-8	1276410	0.16480475	17.4253925	1220443	0.16759437	16.6361282	55967	1161225	0.13894177	15.5501768
Administrative	17-8	1106933	0.14292259	15.1117133	1044132	0.14338289	14.232794	62801	1002536	0.11995447	13.4251433
Directors Fees	18-8							0	0		
Professional Services	19-8	49257	0.00635986	0.67245051	56556	0.00776642	0.77092733	-7299	59573	0.00712797	0.79775296
Fees, Subscriptions, Promotions	20-8	30211	0.00390072	0.41243686	27549	0.0037831	0.37552651	2662	19585	0.00234337	0.26226632
License Fee-IDPA	Pg21	0			400	5.4929E-05	0.00545249	-400			
License Fee-Other	Pg21	1225	0.00015817	0.01672355	625	8.5827E-05	0.00851951	600	1135	0.0001358	0.01519899
Clerical & General Office Expenses	21-8	240392	0.03103842	3.28180205	232735	0.03195977	3.17246221	7657	202376	0.0242145	2.7100541
Employee Benefits & Payroll Taxes	22-8	605451	0.07817332	8.26554266	575682	0.07905413	7.84724854	29769	543790	0.06506503	7.28199154
Payroll Taxes	Pg21	299374	0.03865393	4.08701706	290343	0.03987065	3.95772958	9031	279845	0.03348374	3.74745568
W/C Insurance	Pg21	77192	0.00996671	1.0538157	69234	0.00950739	0.94374395	7958	59369	0.00710356	0.79502116
Health Insurance	Pg21	128483	0.01658919	1.75403413	121695	0.01671147	1.65885143	6788	122879	0.0147026	1.64549521
Inservice Training & Education	23-8	4754	0.00061382	0.06490102	3371	0.00046291	0.04595085	1383	3516	0.00042069	0.0470834
Travel and Seminar	24-8							0	0		
Other Admin. Staff Transportation	25-8	25127	0.00324429	0.34303072	608	8.3492E-05	0.00828778	24519	558	6.6765E-05	0.00747228
Insurance-Prop.Liab.Malpractice	26-8	74201	0.00958052	1.01298294	53715	0.00737628	0.73220103	20486	41683	0.00498741	0.55818469
Other (specify):*	27-8							0	0		
TOTAL General Administration	28-8	2136326	0.27583353	29.1648601	1994348	0.273869	27.1853982	141978	1873617	0.2241802	25.0899486
TOTAL Operation Expense	29-8	6248681	0.80680371	85.3062253	5827248	0.80021269	79.432505	421433	5573248	0.66684487	74.6323852
Real Estate Taxes	33-3	72603	0.0093742	0.99116724	74425	0.01022023	1.01450362	-1822	70426	0.00842654	0.94308747
Real Estate Legal	Pg10	0			0			0	0		
GRAND TOTAL COST	45-8	7744983	1	105.733556	7282124	1	99.2642412	462859	8357638	1	111.918662
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		2977919.37	0.38449657	40.6541894	2807329.23	0.38550967	38.267325	170590.142	2646691.14	0.31667932	35.442326

WESTMONT CONVALESCENT CENTER
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2000

INCOME PER F/S									8,688,600	
	NURSING	EMPL BENEI	PLANT	LAUNDRY	DIETARY	GENL/ADMI	OTHER INC/I	CAPITAL		SALARIES
PER COST REPORT	2,835,945	605451	604318	181589	500540	1601947	118036	1204152		3652955
ADJUSTMENTS:										
EQUIP RENTAL/AUTO LEASE	2980		6731			36581		-46292		
CABLE TV	0		0			0				
CONTRACT NURSING										10450
INTEREST INCOME							(131,272)			
NET VENDING COMMISSIONS							0			
EMPLOYEE PHYSICAL EXAMS		-2492				2492				
INSURANCE - EXECUTIVE LIFE		0				0				
MANAGEMENT FEES						-905000		905000		
BAD DEBTS						-59409	59409			
NURSE AID REIMB-STATE							-16231			
PROFIT SHARING										
PRIOR EXPENSES							12954			
RECLASSED SALARIES	-26478					26478				
RECLASSED SALARIES										
DISCOUNTS							-11388			
ANCILLARY	295,006								-295006	
TOTAL COSTS	3107453	602959	611049	181589	500540	703089	31508	2062860	7801047	3663405
PER FINANCIAL STATEMENTS	3107453	602959	611049	181589	500540	703089	-31508	2062860	1182559	3663405
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									1182559	